



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3543-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: UT SYSTEM REP. BOX #: 46	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the letter, dated 07/27/09 sent to UT Systems Senior Claims Analyst, Juanita Pichler: "...please see the attached invoice last received and the attached copy of my bank statement showing that I paid this invoice with a personal check on 05/20/09 in the amount of \$106.00 on check number 006640. This should have been paid by Workers' Compensation. However, I paid it personally. The requests for payment continue to come each month. Please contact me with your assistance for resolving this matter..."

Principle Documentation:

1. DWC 60 package
2. Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought: \$106.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...Upon review, no money is due from the carrier to the claimant or health care provider in this dispute. The health care provider, Clinical Pathology Laboratories, did not file the bill timely, did not request reconsideration, and improperly billed and was paid by the injured worker. This appears to be an effort by the health care provider to circumvent Division of Workers' Compensation (DWC) Rule 133.20, Medical Bill Submission by Health Care Provider, and Rule 133.250, Reconsideration for Payment of Medical Bills. Additionally, the health care provider appears to be in violation of the Texas Workers' Compensation Act, Sec. 413.042. PRIVATE CLAIMS, ADMINISTRATIVE VIOLATION.

Principle Documentation:

1. DWC 60 package
2. EOB

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/16/08	29	Out of Pocket Expenses	\$106.00	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code 29 – The time for filing has expired.

2. This dispute relates to out-of-pocket expenses paid by the injured worker with reimbursement subject to the provisions of 28 Texas Admin. Code Section §133.270.
3. According to the information submitted by both parties, it appears the health care provider, Clinical Pathology Laboratories, billed the insurance carrier in accordance with 28 Texas Admin. Code Section §133.20, as reflected in the EOB submitted by the injured worker. The insurance carrier denied the payment stating, on the Explanation of Benefits, that the time for filing has expired; the healthcare provider then started billing the injured worker. The injured worker paid the laboratory fees on May 15, 2009 with check number 6640 then requested a refund from the insurance carrier as reflected by the transmission verification report dated July 27, 2009. The insurance carrier responded to the injured workers request for reimbursement and denied the charges with reason code 29. According to Texas Admin. Code Section §133.20, "the health care provider shall not submit a medical bill later than the 95th day after the date the service is provided." The injured worker is not a health care provider and is not bound by the 95 day ruling; however, in accordance with Texas Admin. Code Section §133.307 section (c)(1)(A) the party seeking resolution must file to Medical Fee Dispute Resolution no later than one year after the date of service in dispute.
4. The Division concludes that this dispute was not filed in the form and manner prescribed under Texas Admin. Code Section §133.307 section (c)(1)(A). As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.20, §133.270 and §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

June 25, 2010

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.